	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155365	B. WIN			04/19/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					AST ST		
WABASE	I SKILLED CARE C			WABAS	SH, IN 46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
F0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
F0000							
			F00	00			
			100	00			
	This visit was fo	or the Recertification					
	and State Licer						
	and State Licei	isule sulvey.					
	Survey dates:	April 16, 17, 18 and					
	19, 2012						
	19, 2012						
	Facility number	·· 000256					
		rovider number: 155365					
	AIM number: N/A						
	All Hulliber.	W/FX					
	Survey team:						
	Linn Mackey, F	RN-TC					
	Shelly Reed, R						
	oneny recu, re						
	Census bed typ	oe.					
	SNF: 10						
	Total: 10						
	Census payor t	vpe:					
	Medicare: 2	71					
	Other: 8						
	Total: 10						
	These deficiend	cies reflect state					
		accordance with 410					
	IAC 16.2						
	Quality review	completed on April 26,					
	2012 by Bev Fa						
	· · · · · · · · · · · · · · · · · · ·	- ,					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	3	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000256

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155365	A. BUILDING B. WING	00	COME	E SURVEY PLETED 9/2012
	PROVIDER OR SUPPLIE		710 N E	ADDRESS, CITY, STATE, ZI EAST ST SH, IN 46992	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 2 of 25

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THILD TETH	or condition	155365	A. BUILDING		04/19/2012
		199909	B. WING		04/19/2012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				EAST ST	
WABASH	H SKILLED CARE C	ENTER	WABA	SH, IN 46992	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0242	483.15(b)				
SS=A		NATION - RIGHT TO MAKE			
	CHOICES				
		the right to choose			
		ules, and health care is or her interests,			
		nd plans of care; interact with			
		community both inside and			
		ty; and make choices about			
	aspects of his or	her life in the facility that are			
	significant to the	resident.			
			F0242	F 242 – It is the intent of this facility	05/19/2012
				to assure the resident has the right	
	Based on interv	view and record		to choose activities, schedules, and	
		lity failed to ensure a		health care consistent with his or	
		ven the choice of when		her interests, assessments, and	
				plans of care; interact with member	rs
		morning for 1 of 10		of the community both inside and	
		viewed in a sample of		outside the facility; and make	
		e criteria for choices.		choices about aspects of his or her	
	(Resident #19)			life in the facility that are significant	t
				to the resident.	
				What corrective actions will be	
	Findings includ	e:		accomplished for those residents	
				found to have been affected by the	
				deficient practice?	
	1. During an in	iterview on 4/16/12 at			
	1:33 p.m. and o	on 4/19/12, 2:15 p.m.,		Resident # 19:	
	•	ndicated he was			
		because the facility		Review of this of this resident's	
		the morning and he		current MDS assessment occurred	
		ould like to sleep in		on 5/8/2012 to include his persona	
		I not be woken up.		desire to arise later in the morning.	
		i not be woken up.		The care plan was updated on	
	D. min at the second			5/8/2012 to include the resident's	
		review on 4/19/12,		desire to choose when he desires to	
	•	ecord indicated the		get up in the morning.	
		Set (MDS), dated		This shangs will be six as 5/0/2012	
	2/21/12, the res	sident had a brief		This change will begin on 5/9/2012	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 3 of 25

NAME OF PROVIDER OR SUPPLIER WABASH SKILLED CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) interview mental status (BIMS) scores 15 of 15. BIMS score on the MDS B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992 (X5) PREFIX (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE for this resident.		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155365	A. BUILDING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/19/2012
NAME OF PROVIDER OR SUPPLIER WABASH SKILLED CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Interview mental status (BIMS) scores TO PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT TO THE APPROPRIATE DEFICIENCY) TAG Interview mental status (BIMS) scores TO N EAST ST WABASH, IN 46992 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT TO THE APPROPRIATE DEFICIENCY) TAG Interview mental status (BIMS) scores			155505	B. WING		
WABASH SKILLED CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Interview mental status (BIMS) scores WABASH, IN 46992 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) For this resident.	NAME OF !	PROVIDER OR SUPPLIEF	t			ΡΕ
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Interview mental status (BIMS) scores (EACH DEFICIENCY) PREFIX COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) For this resident.	WABASI	H SKILLED CARE C	ENTER			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (FOR THIS RESIDENCE) FOR this resident.	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDENCEN AN OF CORDER	(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE interview mental status (BIMS) scores for this resident.	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLETION
` ' '	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
15 of 15 RIMS score on the MDS		interview menta	al status (BIMS) scores		for this resident.	
10 of 10. Dilvio doore off the MDO		15 of 15. BIMS	S score on the MDS			
indicated the resident was cognitively How will the facility identify other		indicated the re	esident was cognitively			
intact. Resident 's diagnoses include residents having the potential to be		intact. Resider	nt ' s diagnoses include			
but not limited to, vascular dementia, affected by the same deficient practice and what corrective action		but not limited	to, vascular dementia,		· ·	
depression, and left side hemiplegic.		depression, an	d left side hemiplegic.		'	action
Will be concil.					Tim we takelli	
The Director of Nursing reviewed					The Director of Nursing review	ved
3.1-3(u) (1) each resident's MDS assessment for		3.1-3(u) (1)			each resident's MDS assessme	ent for
the resident's desires. There were 3					the resident's desires. There v	vere 3
other residents identified that would						
like to choose when they get up in					· =	
the morning. Care plans for these residents were revised on 5/8/2012						
to reflect their wishes.						/2012
to reflect their wishes.					to reflect their wishes.	
This change will begin on 5/9/2012					This change will begin on 5/9/	2012
for these residents.					for these residents.	
What measures will be put into					-	
place or what systemic changes will					·	es will
be made to ensure that the						2
deficient practice does not occur?					deficient practice does not of	curr
Upon admission to WSCC, all					Upon admission to WSCC, all	
residents will continue to be						
assessed regarding their personal						
desires. Care plans for all residents					· ·	
will be developed upon admission to						sion to
include these desires.					include these desires.	
A tour of another LTC Skilled facility					A tour of another LTC Skilled f	acility
that employs Resident Centered						
Care is planned and scheduled on					Care is planned and scheduled	d on
May 14, 2012. Leadership from						m
WSCC who will participate in					· · ·	
exchange of information / tour will					=	r will
include Director of Nursing,					include Director of Nursing,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 4 of 25

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155365	A. BUILI B. WING	DING	00	COMPL 04/19/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					Administrator, Dietician, MDS / Care Plan nurse and Social Services / Activities Designee.		
					The Director of Nursing will develop a policy, in conjunction with the Medical Director related to the delivery of personal care per Resident Centered Care model by 5/16/2012.		
					Admission Assessment process will be revised to include Resident Centered Care Activities.		
					Care planning will then individually include, for each resident, their personal desires regarding ADLs and personal care, based on Resident Centered Care Activities.	l	
					Staff education will be conducted or 5/17/2012 regarding changes in care delivery as per policy.		
					How will the corrective action be monitored to ensure the deficient practice does not recur?		
					All resident care plans will be reviewed quarterly and with each significant change in condition by the care plan team and the Director of Nursing or Designee to assure compliance.		
					Quality Assurance Follow-up: The Director of Nursing or Designee		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet Page 5 of 25

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155365	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED - 04/19/2012			
WABASH	ROVIDER OR SUPPLIER	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)				
				will report any deficiencies t Quality Assurance Committe 30 days for the first 90 days, quarterly thereafter.	ee every			
				Date of Compliance: May 1	9, 2012			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 6 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DING	00	COMPLETED	
		155365	A. BUILDING	-	04/19/2012	
		11111	B. WING			
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
				EAST ST		
WABASH	H SKILLED CARE (CENTER	WABAS	SH, IN 46992		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F0248	483.15(f)(1)	,				
SS=D	` ' ' '	EET INTERESTS/NEEDS OF				
00-5	EACH RES					
		t provide for an ongoing				
		vities designed to meet, in				
	. •	the comprehensive				
		e interests and the physical,				
		chosocial well-being of each				
	resident.	•				
			F0248	F248 - It is the intent of this facility	05/19/2012	
	Rased on obse	ervation, interview and		to ensure that all residents receive		
				an ongoing program of activities		
	•	the facility failed to		designed to meet, in accordance		
	•	ngful activities for 1 of		with the comprehensive assessmen	+	
	10 residents in	a sample of 10 who		the interests and the physical,		
	met the criteria	a for activities.		mental, and psychosocial well-being	,	
	(Resident #19	9)		of each resident.		
	(1.00.001.1. // 10	.,,.		or each resident.		
				What corrective actions will be		
				accomplished for those residents		
	Findings include	de:		found to have been affected by the		
				deficient practice?		
				dencient practice:		
	During observa	ations on 4/16/12,		Resident # 19:		
	_	/19/12, Resident #19		Resident # 19:		
	1	to have attended a		December of this resident		
				Reassessment of this resident		
	l	n 4/19/12 at 10:00 a.m.,		occurred on 5/8/2012 to include his		
	which included	d one other resident.		desire for outside activities. The		
				care plan was updated on 5/8/2012		
				to include outside activities for this		
	During an inter	rview on 4/19/12 at		resident.		
	_	esident #19 indicated		Diamed subside		
	· ·	be a carpenter and		Planned outside activities are		
		•		scheduled weekly beginning		
		e was younger. He		5/7/2012.		
		ng with his hands and		Line and the feeting of the second		
	being outside.	Resident #19		How will the facility identify other		
	indicated he fe	els like he is just here		residents having the potential to be		
		nd he is bored.		affected by the same deficient		
			1	practice and what corrective action	1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet Page 7 of 25

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		155365	B. WIN			04/19/2	2012
N	ADOLUDED OF STATE				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			710 N E	AST ST		
WABASH	SKILLED CARE C	ENTER		1	SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident would	I like to go outside of			will be taken?		
	facility for an ou	uting or event.					
	Resident indica	ited that he enjoys			All residents currently in the facility	'	
		vspaper, watching old			will have a new activity assessment		
	movies, and ha	• •			completed by 5/18/2012 with care	9	
					plans for all residents updated by		
					5/18/2012 to include outside		
	Dumina an inter-	view en 4/40/40 -+			activities for all current residents		
	_	view on 4/18/12 at			wishing to participate in outside		
	·	sistant Activity Director			activities.		
	#2 indicated the	e resident enjoys old					
	farm books and	I reading the paper.			What measures will be put into		
	She indicated the resident does have				place or what systemic changes will	"	
	left sided hemir	olegia which does			be made to ensure that the		
	· ·	ipation in some			deficient practice does not occur?		
	•	vity Assistant #2			Within 72 hours of admission to		
		has been no outside			WSCC, all residents will be assessed	1	
					regarding their personnel desire for		
		past three months and			outside activities. Care plans for all		
		the most recent time			residents will be developed after th	٩	
	the residents ha	ave been off the third			admission assessment to include		
	floor facility.				outside activities for all residents pe	er	
					their individual ability and desire.		
	During record r	eview on 4/19/12 at			How will the corrective action be		
	11:08 a.m., a s				monitored to ensure the deficient		
	· ·	mpleted on 11/29/10,			practice does not recur?		
		lent #19 interest					
					All resident care plans will be		
		ot limited to, antique			reviewed quarterly and with each		
	_	ewspapers, following			significant change in condition by		
	high school bas	sketball, and trips.			the care plan team and the Director	r	
					of Nursing or Designee to assure		
					each and every resident's desire for	·	
	3.1-33(a)				an outside activity is included in		
	, ,				their plan of care.		
					Quality Assurance Follow-up:		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet Page 8 of 25

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155365	(X2) MULTIPLE CO A. BUILDING B. WING	00 	COMPL 04/19/	ETED
	PROVIDER OR SUPPLIED		710 N E	ADDRESS, CITY, STATE, ZIP CODE EAST ST SH, IN 46992	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	The Director of Nursing or Design will report any deficient findings the Quality Assurance Committe monthly for the first 90 days; the quarterly thereafter. Date of Compliance: May 19, 20	nee to e en	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

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Facility ID: 000256

If continuation sheet

Page 9 of 25

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPL	ETED
		155365	B. WING			04/19/	2012
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AST ST		
WABASH	I SKILLED CARE C	ENTER			SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279 SS=D	PLANS A facility must us assessment to d resident's compr The facility must care plan for each measurable object a resident's mental and psycidentified in the compression of the care plan mare to be furnished resident's highest mental, and psycinguired under § that would other §483.25 but are	O(k)(1) PREHENSIVE CARE se the results of the evelop, review and revise the ehensive plan of care. develop a comprehensive ch resident that includes extives and timetables to a medical, nursing, and chosocial needs that are comprehensive assessment. set describe the services that ed to attain or maintain the ext practicable physical, chosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10,					
	§483.10(b)(4).	nt to refuse treatment under	F0.0				0.5 (1.0 (2.01.2
	Based on recor		F027	/9	F 279 - It is the intent of this facility		05/19/2012
	·	acility failed to ensure			to ensure that the results of the		
		re plan was initiated for			comprehensive assessment will be used to develop, review and revise		
		reviewed in a sample			the resident's comprehensive plan		
	of 5 who met th	ne criteria for weight			of care. Further this facility will		
	loss. (Resider	nt # 50 and # 45).			develop the comprehensive care		
					plan for each resident that includes		
	Findings include	de:			measureable objectives and		
	Ū				timelines to meet a resident's		
	1. Resident # 5	0's record was			medical, nursing, mental and		
		18/12 at 2:00 p.m.			psychosocial needs that are		
		•			identified in the comprehensive assessment. These care plans must		
	Resident # 50's	s current diagnoses			describe the services that are to be		
	included, but w	ere not limited to			furnished to attain or maintain the		
	status post upp	er gastrointestinal			resident's highest practicable		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 10 of 25

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155365		LDING		04/19/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					EAST ST		
WABASE	I SKILLED CARE C	ENTER	WABASH, IN 46992		SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
	bleed, status p	ost amputation right			physical, mental, and psychosocial		
		onic obstructive			well-being as required under		
	1	ease, cerebral vascular					
	accident, depression and ulcerative esophagitis.				What corrective actions will be		
					accomplished for those residents		
					found to have been affected by the	!	
					deficient practice?		
	The resident's	current diet order was					
	a regular diet.				For resident #50		
	A 4/7/2012 Nut	tritional Assessment			On 4/19/2012, the dietician met		
		dent # 50's height was			with resident and family to discuss		
		ght was 110 pounds.			the resident's nutritional status.		
		•			Resident has agreed to drink an		
		nt also indicated a			Ensure chocolate milk shake 1-2		
	ı ·	t amputation, the			times daily. An order was obtained		
	resident had a	poor appetite, a			from the physician for Ensure		
	current diet of i	regular diet and			chocolate milk shakes 1-2 times		
	percentage of t	food intake was poor.			daily. Attending physician saw		
	'	•			resident on 4/27/2012 and ordered		
	A Dietary note,	dated 4/9/12			Remeron 15 mg at bedtime as an		
		ent was significantly			appetite stimulant. Care plan		
		•			written on 4/19/2012 to address		
	,	eal body weight) of 175			nutritional risk status.		
	l ' '	oor oral intake and was					
	depressed.				Resident #45:		
	Review of the	care plans indicated			No corrective actions can be taken		
		a care plan that			for this resident as this was a review	<i>I</i>	
		ritional needs with the			of a closed record.		
	significant weig						
	i signinoant weig	yı it 1033.			How will the facility identify other		
	D	10.0.50			residents having the potential to be	2	
		12 9:50 a.m., interview			affected by the same deficient		
		an, she indicated they			practice and what corrective action)	
	have 7 days af	ter the care area			will be taken?		
	assessments a	re done to complete					
		The dietician indicated			Review of the current residents and		
	I	ate care needs the			their medical record by the Director	•	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPL	ETED
		155365	B. WIN			04/19/	2012
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			EAST ST		
WARASH	H SKILLED CARE O	PENTED			SH, IN 46992		
WADAGI	· · · · · · · · · · · · · · · · · · ·	ZENTEK		WADAC			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	FERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility uses the	e preliminary care			of Nursing revealed no other		
	plans.				residents were affected by the		
					alleged deficiency.		
	Review of a current policy titled						
		re Plans, received from			What measures will be put into		
	_	sing on 4/19/12			place or what systemic changes wil	ı	
		•			be made to ensure that the		
	indicated that a preliminary plan of care shall be developed for each				deficient practice does not occur?		
		24 hour of resident			At the time of admission any		
		e plan of care needs to			resident who are at nutritional risk		
		nt's immediate needs.			or with a history of a non-planned		
	audress reside	ill 5 illillediale fleeds.			weight loss will have a care plan in		
					place within 24 hours of admission		
					by nursing. Nursing will send the		
	_	sed record review on			dietician a request to see the		
	4/18/12 at 9:41	a.m., Resident #45			resident within 72 hours of		
	was admitted t	o the facility on 3/2/12			admission. The dietician will assess		
	for a right hip f	racture. Admission			the resident and review the plan of		
	weight on 3/2/				care to assure appropriateness. Thi	S	
					will be communicated to staff at the	9	
	The initial dieta	ary assessment was			next staff meeting scheduled for		
		3/2/12. The initial			5/17/2012.		
		dicated the resident's					
					How will the corrective action be		
	,	ght range between			monitored to ensure the deficient		
	·	h an ideal body weight			practice does not recur?		
		sident #45's height was			All resident care plans will be		
	5 '0. "				reviewed quarterly and with each		
	An assessmen	t indicated the resident			significant change in condition by		
	had mild edem	a to lower leg. A			the care plan team and the Director		
		nal assessment was			of Nursing or Designee to assure		
		3/29/12. Resident			compliance.		
		on 3/29/12 was 80 lbs.					
	_	as still noted to have			Quality Assurance Follow-up:		
		a to lower leg. The			The Director of Nursing or Designee		
		naintained on a regular			will report any deficiencies to the		
	diet until discha	arge.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155365	B. WIN			04/19/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	R.		710 N E	EAST ST	
WABASH	SKILLED CARE C	ENTER			SH, IN 46992	
(V4) ID	CLIMMA DAY C	TATEMENT OF DEFICIENCIES		ID	, I	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	l `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
1710	REGUERTORTOR	ESC IDENTIFY THAT IN ORMATION	+	1710	Quality Assurance Committee every	
					30 days for the first 90 days, then	
					quarterly thereafter.	
		veights were reviewed:			quarterly thereafter.	
	3/2/12- 98 lbs.;	3/3/12- 95 lbs; 3/4/12-			Date of Compliance: May 19, 2012	
	95.5 lbs.; 3/5/1	2- 94.75 lbs.; 3/10/12-			Bute of compliance, may 15, 2012	
	93 lbs.; 3/17/12	2- 87 lbs.; 3/24/12-				
	80.25 lbs.;3/31	/12- 84 lbs.;and				
	4/14/12- 83 lbs					
	The weight doc	cumentation sheet				
		10/12 Resident #45				
		Lasix, an antidiuretic				
		e renal excretion of				
	1					
		ication administration				
	· '	vas reviewed. No				
	' '	er was found indicating				
		ed on 3/10/12 or after.				
	A physician's o	rder on 3/15/12 for				
	Hydrochlorothia	azide, a medication				
	used to promot	e renal excretion of				
	fluid, was found	d and the resident was				
	started on this	medication on 3/15/12.				
	Resident #45 d	lid not have a care plan				
		ght loss or nutritional				
	status.	grit 1000 or rideritional				
	Jiaias.					
	During an inter	view on 4/18/12 at				
		istered Dietician #1				
		dent #45 was started				
		0/12, and her weight				
	loss was as a r					
	medication. Sh	ne also indicated the				
	resident did no	t want any type of				
	supplements b	ut could not provide				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 13 of 25

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155365	A. BUILDING B. WING	00	COMPLETED 04/19/2012			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
		ition indicating this.						
	3.1-35(a)(1)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet Page 14 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155365	A. BUII B. WIN			04/19/	2012
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EAST ST		
\\\\AB\\\\	SKILLED CARE C	ENTED			SH, IN 46992		
WADAGI	I SKILLED CAILE C	LIVILIX		WADAC	511, 111 40992		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0325	483.25(i)						
SS=D		RITION STATUS UNLESS					
	UNAVOIDABLE	loutle community					
		lent's comprehensive facility must ensure that a					
	resident -	lacility must ensure that a					
		ceptable parameters of					
		, such as body weight and					
		nless the resident's clinical					
	•	strates that this is not					
	possible; and						
		nerapeutic diet when there is					
	a nutritional prob	lem.					
			F03	25	F 325 – It is the intent of this facility		05/19/2012
	Based on recor	d review and			to ensure that a resident (1)		
	interview, the fa	acility failed to ensure			Maintains acceptable parameters of	:	
	residents with v	•			nutritional status, such as body		
		neters were identified			weight and protein levels; unless the	9	
	• •	ns to prevent further			resident's clinical condition		
		•			demonstrates that this is not		
	•	re developed for 2 of			possible; and (2) receives a		
		eviewed in the sample			therapeutic diet when there is a		
		the criteria for weight			nutritional problem.		
	loss. (Resident	#45 and #50).					
					What corrective actions will be		
					accomplished for those residents found to have been affected by the		
	Findings includ	e:			deficient practice?		
	J				dencient practice:		
					For Resident # 50:		
	1 During a clo	sed record review on					
	•	a.m., Resident #45			On 4/19/2012, the dietician met		
		•			with resident and family to discuss		
		the facility on 3/2/12			the resident's nutritional status.		
	•	acture. Admission			Resident has agreed to drink an		
	•	2 was 98 lbs. The			Ensure chocolate milk shake 1-2		
	initial dietary as				times daily. An order was obtained		
	completed on 3	3/2/12. The initial			from the physician for Ensure		
	assessment inc	dicated the resident's			chocolate milk shakes 1-2 times		
	ideal body weig	ght range between			daily. Attending physician saw		
	,	, G					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet Page 15 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155365	B. WING		04/19/2012
				T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	3		I EAST ST	
WARASH	SKILLED CARE O	ENTER		ASH, IN 46992	
				1	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE .
		h an ideal body weight		resident on 4/27/2012 and ordered	
		ident #45's height was		Remeron 15 mg at bedtime as an	
	5 ' 0. " An ass	essment indicated the		appetite stimulant. Care plan	
	resident had m	ild edema to lower		written on 4/19/2012 to address	
	legs. A second	d nutritional		nutritional risk status.	
	assessment wa	as completed on		Resident #45:	
		dent #45's weight on		nesident #45.	
		•		No corrective actions can be taken	
	3/29/12 was 80 lbs. The resident was still noted to have had mild edema to			for this resident as this was a revie	w
				of a closed record.	"
	lower leg. The				
		a regular diet until		How will the facility identify other	
	discharge.			residents having the potential to b	
				affected by the same deficient	
				practice and what corrective actio	n
	The following v	veights were reviewed:		will be taken?	
	3/2/12 98 lbs.				
	3/3/12 95 lbs.			Review of the current residents and	d
	3/4/12 95.5 lbs			their medical record by the Directo	r
	3/5/12 94.75 lb			of Nursing revealed no other	
	3/10/12 93 lbs.			residents were affected by the	
	3/17/12 87 lbs.			alleged deficiency.	
				l	
	3/24/12 80.25			What measures will be put into	
	3/31/12 84 lbs.			place or what systemic changes w	III
	4/14/12 83 lbs.			be made to ensure that the	
				deficient practice does not occur?	
	The weight doo	cumentation sheet		All weights of the residents will be	
	indicated on 3/	10/12 Resident #45		reviewed monthly by the dietician	
	was started on	Lasix, an antidiuretic		and any significant changes in	
		te renal excretion of		weight will be immediately reporte	d
	•	lication administration		to the physician. The dietician will	
	record (MAR) was reviewed. No			initial the weight book to show tha	t
	physician's order was found indicating			the weight has been reviewed.	
		ted on 3/10/12 or after.			
				How will the corrective action be	
	1	order on 3/15/12 for		monitored to ensure the deficient	
	Hydrochlorothi	azide, a medication	1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	ETED
		155365	B. WIN			04/19/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	₹					
	SKILLED CARE C	CENTED			EAST ST		
WADASI	1 SKILLED CARE C	ZENTER		WADAS	6H, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	used to promot	te renal excretion of			practice does not recur?		
	fluid, was found	d and the resident was					
	•	medication on 3/15/12.			The dietician will monitor the weigh	t	
					of all residents monthly to assure		
					compliance. Any deficiencies will be		
	No physician notification of weight				reported to the Director of Nursing		
					or Designee.		
		. Resident #45 did not					
	•	an to address weight			Quality Assurance Follow-up:		
	loss or nutritior	nal status. No					
	supplements w	ere offered. A dietary			The Director of Nursing or Designee		
	note on 3/27/12	2 indicated the			will report any deficiencies to the		
		ht was reviewed and			Quality Assurance Committee every	'	
	_	weight loss after			30 days for the first 90 days, then		
		o weight loss after			quarterly thereafter.		
	starting Lasix.						
					Date of Compliance: May 19, 2012		
	•	eview on 4/16/12 at					
	4:20 p.m., the I	Minimum Data Set					
	(MDS), dated 3	3/29/12, indicated the					
		Brief Interview Mental					
		score of 15 of 15. The					
	, ,						
	_	noses included, but					
		d to, hip fracture,					
	anemia and hy	pertension.					
	During an inter	view on 4/18/12 at					
	9:46 a.m., Rea	istered Dietician #1					
	_	dent #45 was started					
		10/12, and her weight					
		the medication. The					
	-	tician #1 was informed					
	that no physicia	ans order was found					
	indicating the r	esident was started on					
	Lasix. The RD	indicated she					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet Page 17 of 25

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155365	A. BUILI	DING	NSTRUCTION 00	(X3) DATE COMPL 04/19/	ETED	
		100000	B. WING	_		04/19/	ZU 1Z	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992					
				WADAS	11, 111 40992			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Lasix since it wassessment we Registered Die Resident #45's that she was nowas started on instead. She a resident did no supplements be	esident was on the ras noted on the dietary eight record. Itician #1 reviewed chart and indicated of started on Lasix but Hydrochlorothiazide also indicated the twant any type of aut could not provide ation to support this						
	Resident # 50's on 4/18/12 at 2	s record was reviewed :00 p.m.						
	included, but w status post upp bleed, status po foot (3/12), chro pulmonary dise	s current diagnoses ere not limited to per gastrointestinal ost amputation right onic obstructive ease, cerebral vascular ession and ulcerative						
	Resident "50's a regular diet.	current diet order was						
	indicated Resid 6 foot and weig The assessme	ritional Assessment dent # 50's height was ght was 110 pounds. nt also indicated the partial right foot						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 18 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155365	B. WIN	IG		04/19/	2012
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					AST ST		
WABASH	I SKILLED CARE C	CENTER		WABAS	H, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
İ		s a poor appetite,					
		s a regular diet and					
	percentage of t	food intake is poor.					
	A Dietary note,						
	indicated the re						
	, ,	low IBW (ideal body					
	l	pounds and had poor					
	oral intake and	was depressed.					
		eight record indicated					
		ate of admission					
		ht of 111 pounds on					
		eight of 109.5 on					
		her weights were					
	noted on weigh	nt record.					
	Review of mea						
		esident eats bites to					
	50% of the foo	d offered.					
		care plans indicated					
		a care plan that					
	addressed nutr	itional needs.					
	Dovious of door	or ordere indicated as					
		or orders indicated no					
	dietary suppler	nent.					
	During a 4/16/2	12 at 10:30 a.m.,					
		RN #6, she indicated					
	ordered for Re	ietary supplement					
	ordered for Res	Siderii # 50.					
	During a interv	iowe with staff on					
		iews with staff on					
	4/18/12 at 9:00	a.iii. Wileii					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 19 of 25

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155365		LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	questioned above are weighted. On those residents on day shift with indicated that we for 4 days then CNA # 9 indicated that weights and the days in a row. During a interviolation of the weights and the resident soldent s	but how often residents CNA # 7 indicated are weighted weekly h showers. CNA # 8 veights are done daily weekly with showers. ted they weigh ly unless they are new n they are weighed 4 iew with the Director of on 4/19/12 at 1:00 ated that there was not on Resident # 50. iew with the DON on p.m., she indicated weight was 106.5 today nt had been started on arrent policy titled, Nutrition Risk reived from the DON 0:00 a.m., indicated esidents are weighed and daily for the first 72 kly thereafter, significant weight riewed by the dietician						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet Page 20 of 25

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155365	A. BUILDING B. WING	00	COME	E SURVEY PLETED 9/2012		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 21 of 25

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155365 NAME OF PROVIDER OR SUPPLIER WABASH SKILLED CARE CENTER IDENTIFICATION NUMBER: 170 N EAST ST WABASH SKILLED CARE CENTER IDENTIFICATION TO NEAST ST WABASH, IN 46992 IDENTIFY TO NEAST ST WABASH, IN 46992 IDENTIFY TO NEAST ST WABASH,		T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	DNSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER WABASH SKILLED CARE CENTER WABASH SKILLED CARE CENTER TAG SERBEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO441 A83.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and transmission of disease and infection. (a) Infection Control Program and the prevent the development and transmission of disease and infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with residents or their food, if direct contact with residents or their food, if direct contact with residents or which hand washing is indicated by accepted	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER WABASH SKILLED CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, senitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with residents or their food, if direct contact with residents or which hand washing is indicated by accepted			155365				04/19/	2012
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hands after each direct resident contact for which hand washing is indicated by accepted			ust require staff to wash their					
		which hand wasl	ning is indicated by accepted					
		professional prac	ctice.					
		/ > 1 :						
(c) Linens			handla ataus museesseesse					
Personnel must handle, store, process and								
transport linens so as to prevent the spread of infection.		•	so as to prevent the spread					
70.44		or infection.		EU4	₁₁	FAAA Ikiakhaistaatafahiaf III		05/10/2012
				1044	†1			03/19/2012
to establish and maintain an						to establish and maintain an		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 22 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DINC	00	COMPL	ETED
		155365	A. BUII			04/19/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
14/4 D 4 O I		SENTED			EAST ST		
WABASE	H SKILLED CARE C	JENIER		WABAS	SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Infection Control Program designed		
	Based on obse	ervation, record review,			to provide a safe, sanitary and		
and interview, the facility failed to					comfortable environment and to		
		ion control practices			help prevent the development and		
		•			transmission of disease and		
		ion administration for 1			infection.		
		a sample of 10.					
	(Resident #1).				The (a) infection control program (1)	
					investigates, controls, and prevents		
					infections in the facility; (2) Decides		
	Findings include: 1. During observation of medication				what procedures, such as isolation,		
					should be applied to an individual		
					resident; and (3) maintains a record		
					of incidents and corrective actions		
	_				related to infections.		
		on 4/19/12 at 8:14					
	a.m., Registere	ed Nurse #5 was			The facility must (b) further prevent		
	observed to ha	ve moved 3 pills from			spread of infection (1) isolate		
	one container t	to another with her			patients to prevent the spread of		
	bare hands. T	he medications			infections when determined		
	included were	Calcium, Multi-vitamin,			isolation is necessary, (2) prohibit		
		ry pill. RN #5 was			employees with communicable		
		ust prior to mixing all			disease or infected skin lesions from		
					direct contact with residents or thei	r	
		s together at the			food if direct contact will transmit		
		o then dispense to			the disease; and (3) the facility must	t	
	Resident #1.				require staff to wash their hands		
					after each direct resident contact fo	r	
	During intervie	ew, after the			which hand washing is indicated by		
	observation, R	egistered Nurse #5			accepted professional practice.		
		she used her bare			The feetlists are a second assess he will		
		ched the medications.			The facility personnel must handle, store, process and transport linens		
		sed of the medication			· · ·		
	•				so as to prevent the spread of infections.		
	and restarted h				iniections.		
	administration	for Resident #1.			What corrective actions will be		
					accomplished for those residents		
	Review of the 2	2nd Edition of the			found to have been affected by the	,	
	"Medication Gu	uide for the Long-Term			Todaid to have been directed by the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 23 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DING	00	COMPL	ETED
		155365	A. BUII			04/19/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	2					
14/45401		NEW TER			EAST ST		
WABASE	I SKILLED CARE C	ENTER		WABAS	SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Care Nurse." d	eveloped by the			deficient practice?		
		ety of Consultant			•		
					Resident # 1:		
	Pharmacists includes the following						
	regarding infection control practices:				On 5/8/2012, the Director of Nursin	g	
	"Tablets and capsules should not be				issued a memo to the staff that they	_	
	poured into the nurse's hands or				are required to wear gloves when		
	touched during the medicine pass.				crushing medications and are never		
	The nurse should wear gloves when				to touch the residents' medications		
		in half or touching them			with their bare hands/fingers.		
	for any other re	_			. 5		
	lor arry other re	243011.			How will the facility identify other		
					residents having the potential to be	•	
					affected by the same deficient		
	3.1-18(b)(1)				practice and what corrective action	l	
					will be taken?		
					The Director of Nursing reviewed th	e	
					resident records for residents		
					receiving crushed medications, one		
					additional resident could be affected	d	
					by the alleged deficiency. Staff have	9	
					been told to wear gloves when		
					crushing medications and never to		
					handle the residents' medications		
					with bare hands/fingers.		
					What measures will be put into		
					place or what systemic changes wil	I	
					be made to ensure that the		
					deficient practice does not occur?		
					The current medication		
					administration policy will be revised		
					by 5/11/2012 to include the		
					reference to nurses who are		
					crushing meds to wear gloves. Staff	:	
					will be re-educated on practice and		
					policy revisions on 5/17/2012.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet Page 24 of 25

PRINTED: 05/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED
		155365			04/19/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 710 N EAST ST WABASH SKILLED CARE CENTER WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				How will the corrective action be monitored to ensure the deficient practice does not recur?	
				Random observations of medication passes will be conducted by the Director of Nursing or Designee on weekly basis by observing different staff administering the medications	a
				Quality Assurance Follow-up:	
				The Director of Nursing or Designee will report any deficiencies to the Quality Assurance Committee every 30 days for the first 90 days, then quarterly thereafter.	
				Date of Compliance: May 19, 2012	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QDJB11

Facility ID: 000256

If continuation sheet

Page 25 of 25